

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Wieslawa Hanna Moore, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the “Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

Every person who contravenes an order made under ... section 45 or 47... is guilty of an offence and on conviction is liable,

- (a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or
- (b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

Indexed as: Moore, W. H (Re)

**THE DISCIPLINE COMMITTEE OF THE COLLEGE
OF PHYSICIANS AND SURGEONS OF ONTARIO**

IN THE MATTER OF a Hearing directed
by the Inquiries, Complaints and Reports Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) of the **Health Professions Procedural Code**
being Schedule 2 of the *Regulated Health Professions Act, 1991*,
S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. WIESLAWA HANNA MOORE

PANEL MEMBERS:

S. DAVIS (Chair)
DR. P. GARFINKEL
DR. P. POLDRE
DR. E. ATTIA (Ph.D.)
DR. P. CHART

Hearing Date: April 12, 2013
Decision Date: April 12, 2013
Release of Written Reasons: May 24, 2013

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on April 12, 2013. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Wieslawa Hanna Moore committed an act of professional misconduct:

1. under clause 51(1)(b.1) of the Health Professions Procedural Code which is Schedule 2 to the Regulated Health Professions Act, 1991, S.O. 1991, c.18 (the “Code”) in that she engaged in sexual abuse of a patient; and
2. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the Medicine Act, 1991 (“O. Reg. 856/93”), in that she has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

RESPONSE TO THE ALLEGATIONS

Dr. Moore admitted the second allegation in the Notice of Hearing that she has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Counsel for the College withdrew the first allegation.

FACTS AND EVIDENCE

The following facts were set out in a Statement of Agreed Facts which was filed as an exhibit and presented to the Committee:

Medical Treatment Provided to Mr. X

1. The Defendant, Dr. Moore, met Mr. X in the spring of 2002, while Mr. X was completing a renovation contract at the Clinic A, where she worked in Ottawa. Dr. Moore hired Mr. X to do renovations on her home after he finished the contract at the medical clinic. In the summer of 2002, Mr. X conducted a renovation on Dr. Moore's home.
2. In 2002, Dr. Moore and Mr. X began a romantic and sexual relationship. Shortly thereafter, Mr. X moved into Dr. Moore's home in Ottawa with Dr. Moore and her daughter Ms Y.
3. Between approximately 2002 and 2004, Dr. Moore provided isolated and incidental medical services to Mr. X, including sending Mr. X for testing and administering immunization shots. She did not inform Mr. X's family doctor about all of the care she provided. Dr. Moore did not bill OHIP for these services or maintain a patient chart.
4. By providing incidental medical care to Mr. X during their romantic relationship, Dr. Moore may have caused confusion for Mr. X as to whether Dr. Moore was acting in a personal or professional role, and represented a failure on Dr. Moore's part to understand and maintain appropriate professional boundaries.
5. Dr. Moore states that the romantic relationship ended in or around March 2004.
6. By the end of July 2004, Dr. Moore moved from Ottawa to Brampton. Mr. X remained in Dr. Moore's house in Ottawa until it was sold in July 2005 on the agreement that he would pay rent/utilities. On occasion, Mr. X would travel to Brampton to see Dr. Moore.
7. Between April 24, 2005 and July 28, 2005, Dr. Moore saw Mr. X as a patient at the clinic where she was employed on four occasions, for the following ailments:
 - (a) liquid nitrogen treatment for warts;
 - (b) minor assessments for dry skin; and

- (c) partial assessments for hyperactive airway and repeat of medication Tussionex originally prescribed by his family doctor.
- 8. Dr. Moore's medical chart for Mr. X is attached at Tab 1 [to the Statement of Agreed Facts]. Dr. Moore billed OHIP for these services, as shown by the attached records from OHIP (Tab 2 [to the Statement of Agreed Facts]).
- 9. Dr. Moore acknowledges that she should not have seen Mr. X as a patient at the clinic where she worked given their prior sexual relationship and on-going personal connection.

Medical Treatment of Ms Y

- 10. Between April 24, 2005 and December 29, 2005, Dr. Moore provided medical services to her daughter, Ms Y.
- 11. Ms Y was a second year undergraduate student at the time.
- 12. During this time period, Dr. Moore provided the following medical services to Ms Y at the clinic where she worked:
 - (a) wart assessment and treatment;
 - (b) assessment and treatment of outer ear infection;
 - (c) foreign body removal from ear;
 - (d) acne assessment; and
 - (e) immunization.
- 13. Dr. Moore also referred Ms Y to other physicians for follow up treatment and care, namely a dermatologist and an allergist.
- 14. Dr. Moore billed OHIP for her services, as evidenced by the attached records from OHIP (Tab 3 [to the Statement of Agreed Facts]) and her patient chart is attached at Tab 4 [to the Statement of Agreed Facts].

Professional Misconduct

15. Dr. Moore admits that by providing medical treatment to her daughter and her former partner she failed to recognize and maintain appropriate boundaries, and caused potential confusion as to whether Dr. Moore was acting in a professional or personal role in providing medical treatment, thereby committing acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional.

FINDING

The Committee accepted as true all of the facts set out in the Statement of Agreed Facts. Having regard to these facts, the Committee accepted Dr. Moore's admission and found that she committed an act of professional misconduct, in that she has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

In making this finding the Committee noted such boundary violations as admitted by Dr. Moore are directly addressed in the College Policy Statement #7-06 (Treating Self and Family Members) and are echoed in the Canadian Medical Association's Code of Ethics. Guidance to physicians is clear: physicians should not treat either themselves or family members, except for a minor condition or in an emergency situation and only when another physician is not readily available.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs as follows:

- Dr. Moore appear before the Committee to be reprimanded;
- The Registrar impose the following term, condition and limitation on the certificate of registration of Dr. Moore: Dr. Moore must successfully complete, at her own expense, the College's Understanding Boundaries in Managing the Risks Inherent in the Doctor-Patient Relationship course, within 12 months; and

- Dr. Moore pay costs to the College of \$3650.00

For the reasons that follow, the Committee accepted the joint submission of the parties as to penalty. The Committee considered the circumstances of the misconduct, both aggravating and mitigating factors, relevant penalty principles, the submissions and case law submitted by the parties and the Court's direction as to joint submissions.

Circumstances of the misconduct

Dr. Moore graduated in medicine in Warsaw, Poland in 1978. She came to Canada in 1986 and practised first in Nova Scotia. In 1992 she worked at several clinics in the Ottawa area. She then opened her own family practice where she worked from 1993 to 2004.

Dr. Moore's relationship with Mr. X was complex and started in 2002 when he was employed by her to do some renovations. Between 2002 and 2004, a romantic relationship developed during which time Dr. Moore provided isolated and incidental services to Mr. X for which she did not bill or maintain a chart. She did not inform his family doctor.

Later, in 2005, Dr. Moore saw Mr. X as a patient and acknowledged that she should not have, given their prior sexual relationship and ongoing personal connection. Such blending of relationships and blurring of boundaries can be serious and may lead as in this matter to potential confusion as to whether Dr. Moore was acting in a personal or professional role. This can be a problem for patients and further illustrates the peril that physician's expose themselves to when professional boundaries are not maintained.

Dr. Moore's provision of medical services to her daughter, noted in the medical record and OHIP billing, clearly contravenes the College's Policy on the Treatment of Self and Family Members. Treatment of a family member raises issues in respect to clinical objectivity and also may impair a good relationship with the family doctor. Dr. Moore was working in a clinic setting at the time and could have arranged for her daughter to be seen by another physician.

Aggravating and Mitigating Factors

The Committee considered the fact that Dr. Moore engaged in boundary violations with Mr. X on a number of occasions to be an aggravating factor. Similarly the treatment she provided to her daughter was not an isolated incident.

There were also a number of mitigating factors considered by the Committee as follows:

- Dr. Moore has accepted responsibility for her misconduct thereby saving the time and expense of a contested hearing;
- Dr. Moore has demonstrated insight by proactively taking the College's Understanding Boundaries in Managing the Risks Inherent in the Doctor-Patient Relationship course. She is currently completing the follow-up requirement;
- This is the first time that Dr. Moore has appeared before the Discipline Committee;
- While Dr. Moore did violate professional boundaries, her behavior was not reckless or intentional; and
- Dr. Moore has paid a significant price for her misconduct. She has expressed remorse and has lived with concern respecting the allegations for some considerable time.

Relevant Penalty Principles

The proposed reprimand addresses in a direct way the Committee's view of Dr. Moore's behavior. A reprimand by one's governing body, as noted in *Shainhouse (Re)*, [1992] O.C.P.S.D. No. 4, is a devastating event in the life of a professional. Further the reprimand in this matter should serve as both a specific and general deterrent in respect of similar behavior in the future.

The proposed requirement for Dr. Moore to complete remedial education specifically targets the knowledge and judgment deficits which resulted in the allegations proven in

this matter. This addresses the principle of rehabilitation in a focussed and effective manner. As a consequence the Committee would expect Dr. Moore to be more vigilant and the public will be protected.

The Committee was of the view that costs in this matter are appropriately sought from the member and not borne by the membership at large.

The Committee is aware that the courts have directed that trial judges should not reject joint submissions unless the joint submission is contrary to the public interest and the sentence would bring the administration of justice into disrepute (see *R. v. Cerasuolo*, [2001] O.J. No. 359 (C.A.)).

The Committee reviewed the case law referred to by the parties and has concluded that while each case is unique, it is nevertheless desirable that like cases be treated alike. We consider that the proposed penalty is consistent with the penalty ordered in like cases. For example, in *Kirsh v. CPSO*, [2008] O.C.P.S.D. No. 22, the Discipline Committee of this College considered a case where the substance of the allegation was confusion between a personal and professional relationship as a consequence of failing to set professional boundaries. The penalty ordered in the *Kirsh* case was the same as the penalty requested for Dr. Moore.

For all of the foregoing reasons, the Committee agreed with the joint submission from counsel for the College and the member that the proposed penalty represents an appropriate censure in this matter.

ORDER

Therefore, having stated the findings in paragraph 1 of its written order of April 12, 2013, on the matter of penalty and costs, the Committee ordered and directed that:

2. Dr. Moore appear before the panel to be reprimanded.
3. the Registrar impose the following term, condition and limitation on the certificate of registration of Dr. Moore:

- (i) Dr. Moore must successfully complete, at her own expense, the College's Understanding Boundaries in Managing the Risks Inherent in the Doctor-Patient Relationship course, within 12 months of the date of this Order.
- 4. Dr. Moore pay to the College costs in the amount of \$3,650.00, within 30 days of the date of this Order.

At the conclusion of the hearing, Dr. Moore waived her right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.